STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This Statement of Deficiencies was generated as a result of the annual Medicare recertification survey and complaint investigation conducted at your facility from July 7, 2015 through July 10, 2015, in accordance with 42 Code of Federal Regulations (CFR) Chapter IV Part 483 Requirements for Long Term Care Facilities.

The census was 190 residents. The sample size was 29 residents.

Two complaints were investigated.
Complaint #NV 00043126- The complaint with the following allegations could not be substantiated.

Allegation #1: The facility was dirty and smelled funny.
Allegation #2: The food was disgusting
Allegation #3: When a resident asked for water it took over 2 hours to get the water
Allegation #4: Mold was growing on the walls and floors.
Allegation #5: No one at the facility bothered to feed a resident or help the resident at all.
Allegation #6: A resident went days without food or water.
Allegation #7: The facility staff got mad at a resident for spilling her water.
Allegation #8: The facility staff were mean to a resident they did not help her to the restroom and let the resident sit in urine.
Allegation #9: The facility isolated a resident because the resident had an infection and did not have the infection until the resident arrived at the facility.

The investigation into the allegations included:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/21/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

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F 000	Continued From page 1	F 000		

Observations of the facility during the re-certification survey for meals, cleanliness, smells, water at resident ' s bed side, resident grooming, staff interactions with residents, answering of call lights along with observations of resident rooms for mold on walls and floors.

Interviews were conducted with an a Social Worker, Occupational therapist, Licensed Nurse, nine residents, a Certified Nursing Assistant the Director of Maintenance/Housekeeping and a Housekeeper.

Review of 29 clinical records during the survey process including the resident of concern.

Review of Call Lights, Environmental Services, Hydration, Grievances and Infection Control and Standard Precautions policies.
Complaint #NV00043149 was substantiated.

The allegation the facility did not address the resident's high blood sugar level was substantiated (See F309).

The following allegations could not be substantiated.

Allegation #1 a resident did not receive the proper rehabilitation services because the resident was diagnosed with Shingles and the facility did not walk the resident around the room .
Allegation #2 a resident did not receive the appropriate wound treatment on the resident's knee and proper care of the drainage tube site.
Allegation #3 a resident did not receive the right dose of Coumadin.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

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F 000	Continued From page 2 The investigation into the allegations included: Interviews were conducted with the Director of Nursing (DON), Assistant Director of Nursing (ADON), Nurse Practitioner, Program Director of Therapy, Registered Nurse (RN)/Infection Control Nurse, three Licensed Practical Nurses (LPN), and LPN/Treatment Nurse. Review of seven medical records including the resident of concern. Review of the facility Specific Medication Administration Procedures policy. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, document review and record review, the facility failed to properly assess a resident to self administer their	F 176		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

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F 176	Continued From page 3	F 176		

own medications and had left the medication at the bedside for 1 of 29 sampled residents (Resident #15).

Findings include:

Resident #15

Resident #15 was admitted on 9/26/14, with diagnoses including fracture of the humerus, pain left arm, muscle weakness, poor appetite, dysphagia and osteoarthritis.

On 7/7/15 in the morning, during the initial tour, Resident #15 had a bottle labeled MVI (multivitamin) D3 on her bed table. Tablets were inside the bottle.

Resident #15 was alert and oriented to person, place and time. The resident was able to recall the last holiday that had passed which was July 4th. The resident was able to verbalize her needs. The resident indicated she took a tablet from the bottle every other day. The resident indicated her family members had brought the bottle of medications to her a few months ago.

On 7/7/15 in the morning, the medication nurse LPN (licensed practical nurse) indicated she was aware the resident had a bottle of medications at the bedside. The LPN indicated the resident could not open the bottle due to the safety cap.

On 7/7/15 in the afternoon, Resident #15's MVI bottle was gone from the resident's table. The Resident indicated the nurse took the bottle of medication away and she was informed by the nurse that she was already taking a MVI tablet given by the nursing staff everyday. The resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

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F 176	Continued From page 4	F 176		

indicated she had forgotten she was taking the same medication she was receiving from the nurse.

Resident #15 indcicated the cap of the MVI bottle was placed on loosely on top of the bottle and she did not have to twist the top off but only to lift the top off and obtain the tablet. The resident indicated she would also have her family who came to visit open the bottle if it was closed. The resident indicated the last time she took the medication was two days ago.

There was no documented evidence an order was received from the Physician for the resident to self-administer the MVI tablets every other day.

There was no documented evidence there was an assessment for the resident to self-administer the MVI tablets every other day.

The facility policy titled Self-Administration of Medications and dated February 2015, documented:

-"...In order to maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescribe's order to self-administer.
Procedures
A. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry out this responsibility during the care planning process..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176	Continued From page 5 -"...D. The results of the interdisciplinary team assessment of resident skills and of the determination regarding bedside storage are recorded in the resident's medical record, on the care plan. For each medication authorized for self-administration, the label contains a notation that may be self-administered. E. If the resident demonstrates the ability to safely self-administer medications, a further assessment of the safety of bedside medication storage is conducted..."	F 176		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff provided privacy and dignity to residents during meal and while providing gastrostomy tube (GT) care. Findings include: Resident #2 Resident #2 was originally admitted to the facility on 12/28/10 and readmitted on 8/30/14, with diagnoses including cerebral aneurysm and dementia. On 7/7/15 at 8:36 AM, a Certified Nurse Assistant (CNA) was observed standing while feeding	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 6	F 241		

Resident #2 in the dining room of the locked unit.

On 7/7/15 at 8:40 AM, a CNA indicated staff should be sitting down while feeding the residents to have eye contact with them and to provide dignity to the residents.

On 7/7/15 at 8:55 AM, the CNA confirmed the observation and acknowledged he should be sitting down while feeding the resident to provide dignity to the resident.

Resident #32

Resident #32 was admitted on 2/17/14, with diagnoses including hypertension, dysphagia and status post cerebral vascular accident.

On 7/8/15 at 8:00 AM, medication administration was observed with the LPN (licensed practical nurse) on Resident #32.

On 7/8/15 in the morning, the LPN prepared Resident #32's medications, entered the resident's room and placed the medications on the side table near the wall. The LPN did not shut the resident room door but did pull the curtain for privacy. At one side of the curtain was the resident's bed and the LPN. On the other side of the curtain was the side table in which the medications and Toomey syringe for the gastrostomy tube (GT) were on top of.

The LPN lifted the resident's gown and exposed the resident's GT and abdomen. The LPN opened the curtain and left the curtains open to obtain the GT supplies and the medications. While the LPN was administering the medication, staff were walking outside the room peering in the room. There was no privacy maintained while the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 7 resident was receiving the medications, with the door left open and the curtain pulled open. On 7/8/15 in the afternoon, the LPN indicated the curtain should have been closed while administrating Resident #32's to maintain privacy for the resident. On 7/10/15 in the afternoon, the Director of Nursing confirmed the resident's door should have been closed and the curtain pulled to maintain privacy for the resident when administering GT medications. The facility policy titled Enterel Tube Medication Administration dated February 2015, documented: "...E. Establish the privacy of the patient..."	F 241		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the water temperature within a safe range (95 degrees Fahrenheit to 110 degrees Fahrenheit) for one of two handwashing sinks in the kitchen. Findings include: On 7/8/15 at 9:50 AM, the water temperature of	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 8 the cold water at the handwashing sink located in the dish washing room was very hot to the touch when used for handwashing. The Food Service Director indicated maintenance staff had repaired the sink previously and it had been a problem with the mixing valve. The cold water was tested later in the morning during the kitchen tour and was not hot to the touch. The cold water was checked at 10:55AM, the water measured 130 degrees Fahrenheit. A dietary aid was observed washing their hands and indicated the water was very hot, sometimes too hot, and they would need to walk from the dishwashing room through the food preparation area to use the second handwashing sink. The facility policy for handwashing dated October 2006 documented food handlers must wash their hands before they start work and after 10 specific activities, such as using the restroom. The water temperature for safe handwashing was not included.	F 253		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, document review and record review, the facility failed to; 1)	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 9	F 309		

follow physician orders for administering insulin for 1 unsampled resident (Resident #32) and 1 of 29 sampled residents (Resident #28); 2) follow physician ordered blood pressure (bp) parameters when administering bp medications 1 of 29 sampled residents (Resident #16); 3) follow physician orders regarding tube feeding flushes for 1 of 29 sampled residents (Resident #16); 4) properly provide treatment for residents on dialysis for 1 sampled dialysis resident (Resident #18); and 5) follow physician orders when administering dietary supplements for 1 of 29 sampled residents (Resident #1).

Findings include:

Resident #32

Resident #32 was admitted on 2/17/14, with diagnoses including hypertension, dysphagia and status post cerebral vascular accident.

On 7/8/15 at 8:00 AM, medication administration was observed with the LPN (licensed practical nurse) on Resident #32.

On 7/8/15 in the morning, the LPN checked Resident #32's blood sugar level which was 162 ml/dL. The LPN obtained a vial containing liquid and labeled Humalog 100 units from the medication cart. The LPN proceeded to aspirate the Humalog insulin from the vial with a syringe. The LPN indicated he obtained 3 units of insulin from the vial.

The LPN showed the Inspector the syringe after the medication was drawn from the vial. The level on the syringe showed the amount of Humalog insulin that was drawn up was 2 units. The piston

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 10	F 309		

and liquid stopped on the the second small line of the syringe that indicated 2 units of insulin were drawn up. The LPN administered the 2 units of Humalog insulin subcutaneously to the resident's abdomen.

Resident #32's physician's orders dated 6/13/15, documented a Humalog sliding scale for the resident. The order documented to administer 3 units of Humalog insulin if the resident's blood sugar range was from 151 to 200 ml/dL. The resdient's blood sugar level was 162mg/dL and 3 units should have been administered.

On 7/8/15 at 9:30 AM, the Inspector asked the LPN to show on a new syringe, the same type of syringe used on Resident #32, where 3 units would be. The LPN pointed to the second small line indicating 2 units on the syringe. The LPN counted each line, one unit being the first long line, two units being the first short line after the long line and the third being the second short line after the first long line. The Inspector informed the LPN that the first long line of the syringe represented "0" (zero) and not one unit. The Inspector showed the LPN that the tip of the piston plunger started on the zero line which was the first long line on the syringe.

The LPN confirmed the amount of Humalog insulin given to Resident #32 was 2 units and should have been 3 units as ordered. The LPN indicated he read the syringe incorrectly and should have not counted the first long line as the first unit.

Resident #16

Based on observation, interview, document

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 11	F 309		

review and record review, the facility failed to; 1) follow physician orders for administering insulin for 1 unsampled resident (Resident #32) and 1 of 29 sampled residents (Resident #28); 2) follow physician ordered blood pressure (bp) parameters when administering bp medications or reporting abnormal bp reading for 2 of 29 sampled residents (Resident #16, #8); 3) follow physician orders regarding tube feeding flushes for 1 of 29 sampled residents (Resident #16); 4) properly provide treatment for residents on dialysis for 1 sampled dialysis resident (Resident #18); and follow physician orders when administering dietary supplements for 1 of 29 sampled residents (Resident #1).

Findings include:

Resident #32

Resident #32 was admitted on 2/17/14, with diagnoses including hypertension, dysphagia and status post cerebral vascular accident.

On 7/8/15 at 8:00 AM, medication administration was observed with the LPN (licensed practical nurse) on Resident #32.

The LPN checked Resident #32's blood sugar level which was 162 ml/dL (milliliters/deciliters). The LPN proceeded to aspirate the Humalog insulin from the vial with a syringe. The LPN indicated he obtained 3 units of insulin from the vial.

Observation of the syringe after the medication was drawn from the vial, revealed the level on the syringe showed the amount of Humalog insulin that was drawn up was 2 units. The piston and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 12	F 309		

liquid stopped on the second small line of the syringe that indicated 2 units of insulin were drawn up. The LPN administered the 2 units of Humalog insulin subcutaneously to the resident.

The physician's orders dated 6/13/15, documented a Humalog sliding scale for the resident. The order documented to administer 3 units of Humalog insulin if the resident's blood sugar range was from 151 to 200 ml/dL. The resident ' s blood sugar level was 162mg/dL and 3 units should have been administered.

On 7/8/15 at 9:30 AM, the LPN demonstrated on a new syringe where 3 units would be. The LPN pointed to the second small line indicating 2 units on the syringe. The LPN counted each line, one unit being the first long line, two units being the first short line after the long line and the third being the second short line after the first long line. The LPN was informed the first long line of the syringe represented "0" (zero) and not one unit. The LPN was informed the tip of the piston plunger started on the zero line which was the first long line on the syringe.

The LPN confirmed the amount of Humalog insulin given to Resident #32 was 2 units and should have been 3 units as ordered. The LPN indicated he read the syringe incorrectly and should have not counted the first long line as the first unit.

Resident #16

Resident #16 was admitted on 4/21/15, with diagnoses including subdural hematoma, diabetes, hypertension and chronic respiratory failure.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 13 The physician orders dated 4/21/15, documented to administer (water) flushes of 250 cc (cubic centimeters) every six hours. The physician orders dated 4/23/15, documented to discontinue the previous flush order and to change the flushes to 120 ml (milliliters) water every 8 hours. The Medication Administration Record (MAR) for April 2015, documented to administer gastrostomy tube (GT) water flushes of 120 ml every 8 hours. The flushes were administered 4 times from 4/23/15 to 4/24/15. The flushes were discontinued on 4/24/15. There was no documented evidence an order was obtained to discontinue the 120 ml water flushes through the GT every 8 hours. The June 2015 recapitulation orders documented on 4/23/15, an order was received for 120 ml of water flushes every 8 hours via the GT. Next to the order, " hold " was handwritten. There was no original order to hold the flushes obtained. The June 2015 MAR documented the 120 ml water flushes were on hold for the entire month. The physician orders dated 6/9/15, documented to discontinue free water flushes. The Dietary Progress Notes documented on 5/30/15, 6/16/15 and 6/27/15, the physician ordered for no flushes to be given. The July 2015 recapitulation orders documented the 120 ml water flushes were discontinued on 6/9/15.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 14 The physician orders dated 7/4/15, documented to discontinue free water flush 120 ml every hours via the GT. The July 2015 MAR documented to administer 120 ml water every 8 hours via the GT. The flushes were administered every 8 hours from 7/1/15 to 7/8/15. On 7/8/15 at 2:30 PM, the LPN (licensed practical nurse) indicated Resident was receiving 120 ml of water flushes through the GT. The LPN indicated he had flushed the GT with 120 ml of water earlier. The LPN was not aware the 120 ml water flushes had been discontinued by the physician. The LPN indicated the nurse receiving the physician order to discontinue the water flushes should have discontinued the order on the July 2015 MR form so the nurses would stop administrating the flushes. On 7/8/15 in the afternoon, the Dietary Technician (DT) confirmed the physician requested to have Resident #16's water flushes discontinued for a few months now due to a low sodium level. On 7/10/15 in the morning the Director of Nursing indicated the water flush order for Resident #16 should have been clarified with the physician. Resident #16's physician orders dated 4/22/15, documented Coreg (Carvedilol) 3.125 mg (milligrams) via PEG (percutaneous endoscopic gastrostomy) hold for systolic blood pressure (SBP) less than 130 or heart rate (HR) less than 60 every day. Lisinopril 10 mg every day, hold for SBP less than 130.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 15	F 309		

Resident #16's physician orders dated 4/30/15, documented hold all blood pressure medications due to decreased blood pressure and increased heart rate.

There was no documented evidence a clarification order was obtained on how long to hold the blood pressure medications for.

On 7/10/15 in the morning, the Director of Nursing indicated the order to hold all blood pressure medications needed to be clarified on how long to hold the medications for.

The blood pressure medications (Lisinopril and Carvedilol) were administered the following day on 5/1/15 with no clarification to the order written on 4/30/15, to hold all blood pressure medications.

The May 2015 Physician Orders recapitulation orders signed by the physician, did not document to administer Lisinopril, did not document to hold all blood pressure medications. The orders documented to administer Carvediolo 3.125 mg, there were no blood pressure parameters identified to hold the medication for a systolic blood pressure less than 130 and heart rate less than 60.

There was no documented evidence an order was obtained to discontinue the Lisinopril and to discontinue the blood pressure parameters for Carvedilol.

Resident #16's IV (intravenous) Medication Administration Record (MAR) for May 2015, documented to hold all blood pressure medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 16	F 309		

The Medication Administration Record (MAR) for May 2015, documented the medications Carvedilol and Lisinopril were administered to the resident starting 5/1/15. Both medications documented to hold the medication if the systolic blood pressure was less than 130 or the heart rate was less than 60.

There was no documented evidence a physician order was received to hold Lisinopril if the heart rate was less than 60. The original order on 4/22/15, did not place a heart rate parameter for Lisinopril. There was no documented evidence the May 2015 recapitulation orders, signed by the physician, included an order to administer Lisinopril to the resident.

Resident #16's May 2015 MAR forms documented to administer Carvedilol 3.125 mg but to hold if the systolic blood pressure was less than 130 or the heart rate was less than 60.

The resident's systolic blood pressure was less than 130 and the Carvedilol was administered on 5/8/15, 5/13/15, 5/15/15 and 5/17/15.

The resident's Carvedilol was held on 5/16/15 and 5/20/15 when the resident's systolic blood pressure was below 130.

On 7/10/15 in the morning the Director of Nursing indicated the order should have been clarified to place or discontinue the Carvedilol parameters for May 2015.

Resident #16's May 2015 MAR documented the resident's systolic blood pressure was below 130 and Lisinopril was administered on 5/1/15, 5/9/15,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 17	F 309		

5/11/15, 5/15/15, 5/23/15, 5/26/15 and 5/28/15.

On 7/10/15 in the morning the Director of Nursing indicated the order should have been clarified to continue or discontinue the Lisinopril systolic blood pressure parameters and initiate or discontinue the heart rate parameters in May 2015.

Resident #16's physician orders dated 5/22/15, documented to increase Coreg to 6.250 mg twice a day with parameters to hold if the HR was less than 60. There was no clarification orders obtained to continue the parameters to also hold Coreg if the SBP was less than 130. The May 2015 MR documented the new order to administer Coreg 6.250 mg twice a day and hold if the HR was less than 60. The MR followed the 5/22/15 order and did not include the SBP parameter.

Resident #16's June 2015 recap orders documented to administer Coreg 6.250 mg twice a day and to hold Coreg if the SBP was less than 130 or the HR was less than 60. The physician orders dated 5/22/15, documented to hold Coreg if the HR was below 60. There was no documented evidence to hold Coreg if the SBP was below 130. There was no clarification order obtained to place the SBP parameters.

Resident #16's June 2015 MR form documented to administer Coreg 6.250 mg twice a day and hold if the SBP was below 130 or the HR was below 60. The SBP parameter was circled and underlined. There was no clarification order obtained to determine if the physician continued SBP parameters or discontinued the parameter.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 18	F 309		

Resident #16's June 2015 MR form documented Coreg 6.250 mg was administered at 8:00 AM on 6/1/15, 6/3/15, 6/9/15, 6/11/15, 6/15/15, 6/16/15, 6/19/15, 6/20/15 and 6/27/15, when the SBP was below 130. The 8:00 AM Coreg 6.250 mg dose was held on 6/6/15, 6/7/15, 6/10/15, 6/12/15, 6/13/15, 6/17/15, 6/18/15, 6/21/15 and 6/22/15, also when the SBP was below 130.

Resident #16's June 2015 MR form documented Coreg 6.250 mg was administered at 4:00 PM on 6/1/15, 6/3/15, 6/7/15, 6/9/15, 6/12/15, 6/16/15, 6/19/15, 6/22/15 and 6/23/15, when the SBP was below 130. The 4:00 PM Coreg 6.250 mg Coreg dose was held on 6/5/15, 6/13/15, 6/15/15, 6/20/15, 6/21/15, and 6/30/15, when the SBP was also below 130.

On 7/10/15 in the morning, the Director of Nursing indicated the phycian order for Coreg parameters should have been clarified due to nurses administering the medication or holding the medication if the SBP was below 130.

Resident #16's June 2015 MR form documented to administer Lisinopril 10 mg once a day and to hold the medication if the SBP was less than 130 or the HR was less than 60.

Resident #16's MR form documented Lisinopril 10 mg was administered at 8:00 AM on 6/1/15, 6/3/15, 6/9/15, 6/10/15, 6/11/15, 6/15/15, 6/16/15, 6/19/15 and 6/20/15, when the SBP was less than 130. The Lisinopril 10 mg dose was held on 6/6/15, 6/7/15, 6/12/15, 6/13/15, 6/17/15, 6/18/15, 6/21/15 and 6/22/15, when the SBP was less than 130.

On 7/10/15 in the morning, the Director of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 19	F 309		

Nursing indicated the physician order for Lisinopril was not followed and the nurses were administering the medication or holding the medication when the SBP was below 130.

Resident #18

Resident #18 was admitted to the facility on 3/25/15 with diagnoses of end stage renal disease with hemodialysis three times a week, Diabetes Mellitus type 2, peripheral vascular disease and right below knee amputation.

On 7/9/15 at 9:50 AM, a Licensed Practical Nurse explained when a resident returned from hemodialysis with a catheter port, the procedure required the staff to check the residents vitals, check the bruit and thrill at the catheter port site and the dressing for bleeding. The LPN explained the dressing covering the insertions site of the catheter was removed four hours after the resident returned.

On 7/9/15 at 9:55 AM, the LPN removed the bottom part of the the dressing exposing the insertion site of the catheter.

On 7/9/15 at 11:40 AM, another LPN explained when a resident returned from hemodialysis the procedure was to check the vitals, check for bleeding and swelling and then continue with four hour checks. The dressing was not to be removed and there would not be a bruit and thrill if the resident had a catheter port.

On 7/9/15 at 11:42 AM, an LPN explained when a resident returned from hemodialysis the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 20	F 309		

procedure was to check the site for bleeding, check the vital signs and then check the dressing for bleeding after four hours. The LPN explained the dressing was not to be removed unless the dressing became dirty and there would not be a bruit and thrill at the catheter port site. The LPN explained the orders from the dialysis facility were to be followed.

On 7/9/15 in the afternoon, a Registered Nurse explained all staff were trained in on caring for residents on dialysis when the residents returned from dialysis. The training was provided by the dialysis center on 6/11/15. The training consisted of dietary, signs and symptoms and the machines used during dialysis treatments. The RN explained the procedure was to check for bleeding and the dressing was not to be removed. The RN explained there was not a bruit and thrill at the catheter port site.

The training documents lacked documented evidence the dressing was to be removed four hours after the resident returned from dialysis. The training documents documented in case of bleeding; pressure was to be applied gently, avoid using pressure bandages and the resident would be sent to the emergency room when appropriate.

The Dialysis Protocol dated 5/2014 documented when the resident returns from dialysis the vitals would be taken unless otherwise indicated and the access site dressing would be observed and signs of bleeding would be documented. Dressing would be removed after four hours and the physician would be notified of any abnormalities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 21	F 309		

Resident #1
Resident #1 was admitted to the facility on 6/27/09 and was readmitted on 11/29/10 for diagnoses of dysphagia, seizure, muscle weakness, orpharyngeal phase, and cardiopulmonary arrest.

The physician recapitulation orders for July 2015 documented an order for 2.0 Calorie 100 cubic centimeters (cc) to be given twice a day (BID) beginning 2/2/12. The orders also indicated it was to be given four times a day (QID).

Resident #1's medication administration record for the following months indicated the 100 cc of 2.0 cal was given four times a day (QID):
7/15, 6/15, 4/15, 3/15, 1/15, 12/14, 11/14, 10/14, 9/14, 8/14, 7/14, and 6/14.

Resident #1's medication administration record for the following months indicated the 100 cc of 2.0 cal was given two times a day (BID):
5/15 and 2/15

On 7/8/15 at 4:55 PM, the Assistant Director of Nursing (ADON), confirmed Resident #1 was receiving 2.0 cal regularly QID. The ADON further verified the physician's order recap was documented as BID for 2.0 cal.

Resident #28

Resident #28 was originally admitted to the facility on 9/27/11, readmitted on 6/9/15, and was discharged on 6/18/15, with diagnoses including acute cholecystitis, diabetes mellitus, and herpes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 22	F 309		

zoster.

The physician's orders dated 6/9/15, indicated accucheck (blood sugar monitoring) before meals and at bedtime with the following insulin Lispro sliding scale coverage:

-2 units (u) of insulin to be given for BS (blood sugar) results ranging from 151-200 mg/dL (milligrams per deciliter).
-4 u for 201-250mg/dL.
-6 u for 251-300 mg/dL.
-8 u for 301-350 mg/dL.
-10 u for 351-400 mg/dL.
-12 u and call physician for BS greater than 400 mg/dL.
-less than 60 mg/dL, initiate hypoglycemic protocol.

The resident's Medication Administration Record (MAR) dated 6/9/15, documented the accucheck was scheduled at 7:00 AM, 11:00 AM, 4:00 PM, and 8:00 PM.

The MAR dated 6/9/15, lacked documented evidence the resident received the amount of insulin per the physician's orders on the following dates and times:

-6/10/15 at 7:00 AM, BS was 270 mg/dL
-6/10/15 at 11:00 AM, BS was 257 mg/dL
-6/11/15 at 7:00 AM, BS was 283 mg/dL
-6/11/15 at 11:00 AM, BS was 308 mg/dL
-6/12/15 at 7:00 AM, BS was 334 mg/dL
-6/12/15 at 11:00 AM, BS was 380 mg/dL
-6/13/15 at 11:00 AM, BS was 265 mg/dL
-6/14/15 at 11:00 AM, BS was 212 mg/dL
-6/15/15 at 4:00 PM, BS was 222 mg/dL
-6/15/15 at 8:00 PM, BS was 216 mg/dL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 23 -6/16/15 at 8:00 PM, BS was 204 mg/dL -6/17/15 at 11:00 AM, BS was 200 mg/dL -6/18/15 at 11:00 AM, BS was 167 mg/dL The MAR dated 6/9/15, lacked documented evidence of the blood sugar results on 6/14/15 at 4:00 PM and 8:00 PM, and on 6/15/15 at 11:00 AM. On 7/10/15 at 8:11 AM, the Assistant Director of Nursing (ADON) confirmed the findings and indicated the blood sugar results and the amount of insulin given to the resident should be documented in the MAR. On 7/10/15 at 8:35 AM, a Licensed Practical Nurse (LPN) revealed the MAR was the only form used by the nurses to document the blood sugar results and the amount of insulin given to the residents. The LPN confirmed there was no complete documentation of the amount of insulin received by Resident #28 per the physician's orders. The facility's policy titled "Specific Medication Administration Procedures" dated 2/15, documented After administration, return to cart, replace medication container (if multi-dose and doses remain), and document administration in the MAR or TAR (Treatment Administration Record).	F 309		
F 322 SS=D	Complaint #NV00043149 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that --	F 322		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 322	Continued From page 24 (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, document review and record review, the facility failed to properly check gastrostomy tube (GT) residual fluid amounts prior to administering medications through the GT for 1 unsampled resident (Resident #32). Findings include: The facility policy titled Enteral Tube Medication Administration dated February 2015, documented: "...8) With gloves on, check for proper tube placement using air and auscultation only. Never check placement with water 9) Check gastric content for residual feeding.	F 322		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 322	Continued From page 25	F 322		

Return residual volumes to the stomach. Report any residual above 100 ml (milliliters)..."

Resident #32

Resident #32 was admitted on 2/17/14, with diagnoses including hypertension, dysphagia and status post cerebral vascular accident.

On 7/8/15 at 8:00 AM, medication administration was observed with the LPN (licensed practical nurse) on Resident #32.

On 7/8/15 in the morning, the LPN prepared Resident #32's medications. The LPN entered the resident's room, placed the medications on the side table near the wall and closed the privacy curtain. The LPN turned off the resident's GT feeding and pulled the resident's gown up to access the resident's GT. The LPN opened the curtain and obtained the Toomey syringe from the side table and and connected it to the resident's GT. The LPN checked for placement by infusing air from the syringe and listened for air sounds with the stethoscope. The LPN did not aspirate back with the Toomey syringe piston to check for residuals but immediately disconnected the syringe from the GT, prepared the medication and reconnected the syringe without the piston to the GT. The LPN started to administer the medication through the GT but had a difficult time gravity administering the medications having to stop several times to manipulate the tube.

On 7/8/15 in the afternoon, the LPN indicated he always checked for GT residuals prior to administering medications through a GT and thought he had checked for GT residuals prior to administering Resident #32's medications. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 322	Continued From page 26 LPN indicated he was nervous and may have forgotten. On 7/10/15 in the morning, the Director of Nursing confirmed GT residuals should have been checked prior to medication administration.	F 322		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a tab alarm was in placed per the physician's order for 1 of 29 sampled residents (Resident #2); and failed to ensure care supplies and wound cleanser were secured in the rooms of 1 of 29 sampled residents (Resident #10) and 2 unsampled residents (Resident #30 and #31); and 1 of 1 sampled resident was supervised while taking medications. (Resident #13). Findings include: Resident #2 Resident #2 was originally admitted to the facility on 12/28/10 and readmitted on 8/30/14, with diagnoses including cerebral aneurysm and	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 27	F 323		

dementia.

The physician's order dated 8/30/14, documented tab alarm at all times for resident safety awareness.

On 7/7/15 at 12:35 PM, the resident was in bed without the tab alarm.

On 7/7/15 at 12:42 PM, the Licensed Practical Nurse (LPN) confirmed the observation and indicated the resident should have the tab alarm as a safety precaution. The LPN acknowledged the physician's order was not followed.

Resident #10

Resident #10 was admitted to the facility on 12/1/13, with diagnoses including Alzheimer's disease and dementia.

During the initial tour on 7/7/15 in the morning, the resident was in bed and eating breakfast. A bottle of shampoo and body wash was found on top of the bedside table of the resident.

Resident #30

Resident #30 was admitted to the facility on 8/2/13, with diagnoses including senile and presenile organic psychosis and bacteremia.

During the initial tour on 7/7/15 in the morning, a bottle of shampoo and body wash was found on top of the bedside table of the resident.

On 7/7/15 at 8:55 AM, the LPN confirmed the observations for Resident #10 and #30 and indicated the bottles of shampoo and body wash

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 28	F 323		

should not be placed on top of the resident's bedside table for safety concerns. The LPN revealed the residents in the locked unit could possibly drink the shampoo and body wash.

Resident #31

Resident #31 was originally admitted to the facility on 5/25/13 and readmitted on 5/4/15, with diagnoses including dementia and open wound of forehead.

During the initial tour on 7/7/15 in the morning, a medication labeled "Sea-Clens Wound Cleanser Spray 178 ml (milliliter)" was found on top of the bedside table of the resident.

On 7/7/15 at 9:35 AM, a Certified Nurse Assistant (CNA) confirmed the observation and acknowledged the wound cleanser should not be left on top of the resident's bedside table but should be kept inside the medication cart for safety issues.

On 7/10/15 at 11:00 AM, the LPN/Treatment Nurse indicated the would cleanser should be kept inside the medication/treatment cart for safety concerns because the residents could possibly consume the cleanser.
Resident #13 was admitted 7/2/15, with diagnoses including urinary tract infection (UTI), bilateral lower extremity lymphedema, and bilateral lower extremity cellulitis.

On 7/7/15 during the initial tour at 8:20 AM, Colace 100 milligrams (mg) was found in a medicine cup on the residents' breakfast tray. Resident #13 indicated she did not want to take this medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 29 At 8:30 AM, the Licensed Practical Nurse (LPN) verbalized there was not a facility policy that said medications may be left at the resident's bedside. Resident #13 said the medications were left to take after breakfast, but the resident did not want to take the Colace. On 7/8/15 at 12:20 PM, another LPN confirmed medications were not to be left at the resident's bedside. The LPNN said you need to see the resident swallow the pills. Another LPN confirmed leaving medications at the residents bedside was a hazard risk as the resident may choke while unsupervised. Facility policy titled Specific Medication Administration Procedures dated February 2015, lacked documented evidence of information regarding residents' supervision while taking medications.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 30	F 329		

who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, document review and record review, the facility failed to properly reduce the use of antidepressant medications when the pharmacist recommended to discontinue the use of one out of the two anti-depressant medications for 1 of 29 sampled residents (Resident #25).

Findings include:

The facility policy titled Medication Regimen Review dated 2/2015, documented:

-"...E. The consultant pharmacist identifies irregularities through a variety of sources including: Medication Administration Records (MARs); orders; progress notes of prescriber, nurses, and/or consultants; the Resident Assessment Instrument (RAI); laboratory and diagnostic test results; behavior monitoring information; the facility staff; the attending physician, and from interviewing, assessing, and/or observing the resident. The consultant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 31	F 329		

pharmacist's evaluation includes, but is not limited to reviewing and/or evaluating the following:..."

-"...8) Duplication of medication orders includes a written rationale for the duplication and evidence of monitoring for both efficacy and cumulative adverse medication effects..."

-"...Resident is monitored for adverse consequences when there is an addition or deletion of a medication, or a change in dose..."

-"...G. Recommendations are acted upon and documented by the facility staff and or the prescriber.
1) Physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing..."

Resident #25

Resident #25 was admitted on 12/9/14, with diagnoses including debility, pressure ulcer, muscle weakness, and hypertension.

On 7/9/15 in the morning, Resident #25 was in her room eating breakfast. The resident was smiling, very verbal and calm. The resident had no negative issues regarding the facility and indicated she liked the food and the facility.

Resident #25's July 2015 Physician Orders form, signed by the physician, revealed Zoloft 25 milligrams (mg) one tablet once a day was ordered on 12/9/14, for depression. Also, Remeron 15 mg one tablet once every night was ordered on 12/18/14, for depression.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 32 Resident #25's Pharmacist Progress Note/Medication regimen Review form, documented on 2/5/15: -"...Resident is currently receiving Zoloft 25 mg daily for depression with Remeron 15 mg q.h.s. (every night) also recently added. Current dose of Zoloft is only a starting dose and not likely providing much benefit. Given the recent addition of Remeron, recommend discontinuing Zoloft..." The 2/5/15 recommendation to discontinue the Zoloft was signed by the physician but there was no indication to continue or discontinue the Zoloft dose by the physician on the form. There was no documented evidence found in the resident records, including the physician notes, reasons to continue the Zoloft dose which the Pharmacist recommended to discontinue due to the resident already being on an anti-depressant medication which was Remeron. On 7/10/15 in the morning, the Director of Nursing (DON) indicated there was another form for the physician to accept or reject the recommendations of the Pharmacist. The DON indicated the recommendation form to accept or reject the recommendations of the Pharmacist was recently implemented and may have not been completed for Resident #25's 2/5/15 recommendations to discontinue Zoloft.	F 329		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 33 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain food contact surfaces and utensils in a clean manner for one food mixer and 5 utensils. Findings include: On 7/8/15 observed the food mixer with a plastic covering. The mixer had been cleaned. Food particles, grease and water residue were observed along the interior edges where the mixing bowl attaches to the base unit, the underside of the top portion of the mixer and inside the mixing bowl. Observation of scoops, ladels, spoodles and pastry knives stored in the clean holding bin revealed food debris and particles were still present on three scoops, one spatula and one pastry knife after they had been through the dish washing process.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 34 of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and document review the facility failed to ensure an appropriate type of isolation was used for 1 of 29 sampled residents (Resident #28).	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 35	F 441		

Findings include:

Resident #28

Resident #28 was originally admitted to the facility on 9/27/11, readmitted on 6/9/15, and was discharged on 6/18/15, with diagnoses including acute cholecystitis, diabetes mellitus, and herpes zoster (shingles).

The physician's order dated 6/9/15, documented droplet isolation for shingles for Resident #28.

The Nurse's Notes from 6/9/15 to 6/15/15 at 3:00 AM, revealed the resident was on droplet isolation for shingles.

The Wound Progress Notes dated 6/10/15 at 8:00 AM, indicated the resident was on Acyclovir for mid lower back shingles.

The facility's Infection Control Report from 6/1/15 to 6/30/15, indicated the resident's site of infection was the skin, with the diagnosis of shingles, and was on isolation.

The Post Acute Progress Note dated 6/12/15, documented the resident was on isolation secondary to MRSA (Methicillin-Resistant Staphylococcus Aureus) nares.

The physician's order dated 6/15/15, indicated to discontinue the isolation.

The resident's medical record lacked documented evidence the resident was monitored and treated for MRSA nares.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 36	F 441		

On 7/9/15 at 3:31 PM, the Licensed Practical Nurse (LPN)/Treatment Nurse revealed the resident's shingles on mid lower back was not active and was not moist.

On 7/10/15 at 8:29 AM, the Nurse Practitioner indicated the droplet isolation was for the resident's MRSA nares and not for shingles. The Nurse Practitioner revealed the resident's shingles was not active and droplet isolation was not appropriate for shingles. Contact isolation should be used for shingles.

On 7/10/15 at 8:50 AM, the Registered Nurse (RN)/Infection Control Nurse indicated the facility only used contact and droplet for isolation and was not capable of providing airborne precautions. Shingles would always be on droplet isolation. The RN/Infection Control Nurse revealed the facility used the guidelines from the Centers for Disease Control and Prevention (CDC) and the Association for Professionals in Infection Control and Epidemiology (APIC). The RN/Infection Control Nurse confirmed Resident #28 was on droplet isolation for shingles.

On 7/10/15 at 9:30 AM, the Director of Nursing (DON) indicated Resident #28 had MRSA nares and shingles. The droplet isolation was for the MRSA nares and not for shingles. The DON revealed she expected the nurses to clarify the physician's order to indicate the appropriate type of isolation for the resident.

On 7/10/15 in the morning, two LPN's acknowledged contact isolation should be used for shingles and the physician's order should be clarified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 37 The facility's policy titled "Categories of Transmission-Based Precautions" dated 6/1/08, documented: "...Droplet Precautions In addition to Standard Precautions, implement Droplet Precautions for an individual documented or suspected to be infected with microorganisms transmitted by droplets (large-practical droplets [larger than 5 microns in size] that can be generated by the individual coughing, sneezing, talking, or by the performance of procedures such as suctioning)..." The CDC's "2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings" and APIC's 2009 "Infection Prevention Manual for Long-Term Care Facilities" indicated airborne and contact as the types of isolation for shingles.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 38	F 514		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure an order for fluid restriction and a psychoactive medication prescription and consent were properly documented or completed and faciled to ensure documentation regarding meal intake percentages were completed for 3 of 29 sampled residents (Resident #18. #23, and #24).

Findings include:

Resident #18

Resident #18 was admitted to the facility on 3/25/15 with diagnoses of end stage renal disease with hemodialysis three times a week, Diabetes Mellitus type 2, peripheral vascular disease and right below knee amputation.

On 7/9/15 at 9:30 AM, the bedside table of Resident #18's room contained two 8 ounces bottles of water and a full pitcher of water with in reach of the resident.

On 7/9/15 at 9:45 AM, a Licensed Practical Nurse explained if a resident was on fluid restriction the resident should not have liquid on the bedside table.

The clinical record documented fluid restriction input and output sheets for April 2015, May 2015, June 2015 and July 2015 for 2 liters of water a day.

The dietary communication form documented the resident was on a regular diet with no restrictions. The tray card documented the resident was on a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 39	F 514		

regular diet with no restrictions.

On 7/9/15 at 11:34 AM, the dietary manager explained if a resident came into the dining room and was on fluid restriction, the nurse in the dining room told the dining staff the resident was on fluid restriction. The Dietary Manger confirmed the resident's tray card did not have fluid restriction documented on the card. The Dietary Manager explained any dietary changes would come form the nursing department.

On 7/9/15 at 11:45 AM, The Dietary Supervisor confirmed there were no changes from the nursing department reflecting the resident was on fluid restriction.

On 7/9/15 at 12:03, the resident had an empty container of jello on the bedside table with a full pitcher of water and two 8 ounce bottles of water.

On 7/9/15 at 12:10 PM, a Certified Nursing Assistant (CNA) explained if a resident was on fluid restriction, the information would be on the tray card which came from the kitchen. The CNA reported the resident had coffee at breakfast, juice and coffee at lunch. If the resident had Jello, this would be considered a liquid.

On 7/9/15 at 1:50 PM, a CNA explained sometimes the CNAs would float to other halls. The CNA reviewed the tray card and explained the resident was on a regular diet with no restrictions and if the resident requested coffee, juice or water, the CNA would serve the resident the requested items.

On 7/9/15 at 1:55 PM, a CNA explained the tray card did not document the resident was on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 40	F 514		

restricted liquids and the resident was able to request more liquids and the CNA would serve the liquids.

The policy, Fluid Restrictions, dated 1/2006 documented residents on fluid restriction were served a dry tray from the kitchen and nursing would supply the beverages according to the amount of restriction. The fluid intake would be documented on the fluid intake flow sheet and the flow sheet would be kept in the medication administration record.

The policy, Dietary-Fluid Restriction monitoring main dining room, dated 1/2014 documented the nursing personnel who were assigned to the Main Dining Room would be notified by Dietary staff if a resident was on fluid restriction.

On 4/30/15 an order for Trazadone 50 milligrams (mg) by mouth once a day at night was prescribed for Resident #18 for insomnia. The original copy of the order documented the medication was prescribed daily and the chart control copy documented the medication was prescribed as needed (PRN).

The physician orders for 7/1/15 through 7/31/15 documented the medication was prescribed for insomnia daily.

On 7/9/15 at 9:55 AM, an LPN explained the resident was administered the medication as a PRN.

The Medication Record for May 2015, June 2015 and July 2015 documented the medication Trazadone 50 mg give one tablet by mouth daily at night for insomnia. A note was typed on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 41 Medication record, See Rainbow sheets. The Rainbow sheets documented the resident was receiving the medication Trazadone 50 mg taken by mouth at night as a PRN for May 2015, June 2015 and July 2015. The behaviors and Non pharmalogical interventions were documented. The policy, Nursing-physician orders/nursing responsibility/role in follow through, dated 6/2011 documented physician orders must be documented completely with sufficient content to clearly convey the provider's intent. Orders that were not clear must be clarified. The statement of consent section of the Psychoactive medication consent form was not completed for Resident #18. This section verified if the resident did consent or did not consent to the administration of the medication, Trazadone. The policy, Use of psychoactive medications, dated 4/2013 documented, consent for the use of psychoactive medications must be received from the resident/legal guardian prior to the administration of the medication and if there was a change in the dosage. Resident #23 Resident #23 was admitted to the facility on 9/26/12 with a diagnoses of muscle weakness, symbolic dysfunction, debility, anemia, and a history of a stroke (CVA). Resident #23's medical records lacked evidence of meal intake portions being documented consistently for three meals a day. February 2015 missing 9 meals March 2015 missed 2 meals April 2015 missed 4 meals May 2015 missed 26 meals	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

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F 514	Continued From page 42 June 2015 missed 7 meals up to July 9 2015 missed 1 meal Resident #24 Resident #24 was admitted to the facility on 02/25/05 with a diagnoses of a large sessile cecal mass, muscle weakness, hemicolectomy, and disease of the pancreas. Resident #24's medical records lacked evidence of meal intake portions being documented consistently for three meals a day. January 2015 missed 12 meals February 2015 missed 19 meals March 2015 missed 7 meals April 2015 missed 6 meals May 2015 missed 17 meals June 2015 missed 5 meals Facility policy on the subject of nutrition intervention for risk for weight loss, effective 2/09, explained the need to recognize if the resident had inadequate intake or less than 50% of a meal in order to continue with the required interventions. Facility policy on the subject of weight loss and weight gain, effective 4/09, explained the requirement for nursing staff and dietary staff to look in the medical chart for changes of appetite in the case of true weight loss.	F 514		